

Program Description

Mission and Authority

The mission of the Indian Health Program (IHP) is to improve the health status of AI/ANs living in urban, rural, and reservation or rancheria communities throughout California. Health services for American Indians are based on a special historical legal responsibility identified in treaties with the U.S. government. California voluntarily accepted this responsibility by adopting Public Law (P.L.) 83-280 in 1954, which allowed for State jurisdiction of Indian affairs. The legislative authority for the program is Health and Safety (H&S) Code, Sections 124575 – 124595 and Title XVII Chapter 3.1, Section 1500-1541.

Population Characteristics

According to the 2000 United States Census, there were 627,562 AI/ANs living in California. This included 333,346 people who classified themselves as AI/AN and an additional 294,216 who classified themselves as AI/AN and one or more other races. The AI/AN population in California is comprised of members of indigenous California tribes as well as members of tribes from throughout the United States. There are more than 107 indigenous California tribes, representing about 20 percent of the nation's approximately 500 tribal groups.

Historical Overview of Health Services

U.S. treaty provisions guarantee health and social services to American Indians. However, the development of a Federal Indian Health Service (IHS) system in California was slow and fragmented as a result of eighteen treaties signed but not ratified. Consequently, Federal health resources to the State between the mid 1850's-1950's were almost nonexistent, consisting of several small sanitation projects, TB sanitariums, and two hospitals located in isolated areas.

A series of federal and state reports documented alarming deficiencies in the health status of Indians. A report issued by the California Indian Commission in 1963 reported rates of T.B., infant mortality, alcoholism, diabetes, and other diseases higher than rates for the general population. This report prompted activity within the Department of Health Services (DHS) in regards to Indian health. Small demonstration projects were conducted with support of federal Maternal and Child Health (MCH) monies and a temporary office of Indian Health was established in 1969.

The office assisted Indian communities to organize local primary care clinics, eventually resulting in the establishment of a network of such clinics throughout the state. A community Board of Directors or Tribal Council governs each clinic. The passage of SB 52 in 1975 represented the first efforts of the Legislature to directly address Indian health. SB 52 directed DHS to create an Indian health branch with a budget to conduct local programs. The branch was reduced to program status in 1983 as part of the Rural Health Act (SB 1117).

Historical Overview of IHP Funding

IHP is funded by the State General Fund on an annual basis. Recommendations for division of these funds to support direct clinic services and other projects is provided to CDHS by the AIHPP.

Indian health clinics are selected for program participation through a Request for Application process, which is released on a three-year cycle. During this time, new clinics are eligible to apply for participation in the IHP. Funding for continuing and new Indian health clinics is determined by two methods. Funding for continuing clinics is determined by an allocation formula. Funding for new clinic awards is dependent on the total IHP funds available and has ranged from \$40,000 to \$80,000 per clinic for their first fiscal year (FY). Funding for new clinics in subsequent FYs is determined by the IHP clinic allocation formula.

Other than a 4% decrease in 1991 and a 65% cut in program staff support in FY 1991-1992, the IHP budget experienced few changes. In 1995-1996 the IHP budget was augmented by 1 million dollars. This 35 percent increase resulted in a \$3,876,000 budget for the IHP in FY 1996-1997.

In FY 1999-2000, the IHP received a 2 million dollar budget augmentation resulting in total IHP funding of \$5,876,000.

In FY 2000-2001, the IHP received an additional increase of \$588,000 (10 percent of the previous year's final budget amount), which resulted in the current annual allocation of \$6,464,000.

From 1980-1993, IHP funds were distributed to the same group of clinics. In FY 1993-1994 legal considerations prompted a policy to open the program to all eligible Indian clinics every fourth year through a RFA process. Since then the IHP has funded about a dozen additional clinics.

Health Status

In 2000 a total of 2.5 million persons (0.9% of the U.S. population) classified themselves as American Indians/Alaska Natives (AI/AN) alone and 4.1 million (1.5%) classified themselves as AI/AN alone or in combination with another race. Approximately 26 percent of AI/AN lived in poverty, which was twice the national rate and the highest poverty rate of all racial/ethnic populations.

AI/AN experience persistent socioeconomic burdens and significant health disparities in their rates of diabetes, cancer, injuries, and pulmonary diseases.

Statistics that reflect the overall low health status of American Indians in California include:

- 16 percent of American Indian births in 2002 were to teen moms compared to 10 percent for Whites.
- There were 8.1 deaths per 1000 American Indian live births in 2001 compared to 4.7 for Whites. This rate discrepancy was probably even higher though as it does not include the finding of an IHP study that showed misclassification on death certificates for American Indian children under age 15 was three to four times greater than reported in state mortality data.

- 74 percent of American Indian mothers in 2001 received first trimester prenatal care as compared to 90 percent for Whites.
- Diabetes prevalence for ages 50-64 is consistently higher among AI/AN (19.6%) as compared to Whites (8%).
- AI/AN with diabetes have a high incidence of diabetes complications such as eye, kidney, lower extremity amputations, and cardiovascular disease. Cardiovascular disease was the leading cause of death in AI/AN and diabetes is a high contributing risk factor for cardiovascular disease.
- Diabetes mellitus is one of the most serious health challenges facing AI/AN in the United States today. Diabetes contributes to several of the leading causes of death in American Indians - heart disease, cerebrovascular disease, pneumonia, and influenza. On average, AI/AN are 2.6 times as likely to have diabetes as non-Hispanic whites of a similar age.
- From 1999 through 2001, AI/AN had significantly higher average death rates due to chronic liver disease and cirrhosis.
- From 1999 through 2001, AI/AN females in California had the highest average death rate from accidents. Injuries cause 75% of all deaths among Native Americans age 19 and younger. The overall death rate from preventable injuries remains nearly twice as high for native people as for the general population.

IHP Program Activities

Existing law directs the CDHS to address the comparatively low health status of the AI/AN population through the maintenance of a program consisting of all of the following:

- **Technical and financial assistance to local agencies concerned with the health of American Indians and their families:** Financial assistance funds 29 American Indian clinics and two Traditional Indian Health education projects. Technical assistance includes quality of care reviews, program planning, and evaluation. IHP also manages 7 Human Immunodeficiency Virus Testing and Counseling grants, and a home visitation program targeted at high risk AI/AN pregnant and parenting families using federal funding.
- **Studies of the health and health services available to American Indians and their families throughout the state:** The IHP assisted with the completion of a congressionally mandated statewide report regarding the health status of nonfederal recognized Indians. The IHP also funded the LA Feasibility Study, which examined options for the development of health care services to AI/ANs residing in LA County.
- **The American Indian Health Policy Panel (AIHPP):** The AIHPP is the IHP's statutorily mandated advisory panel. The AIHPP provides advice to CDHS and IHP on the level of resources, priorities, criteria, and guidelines necessary to implement the Indian Health Program. AIHPP members are nominated by their respective communities and are appointed by the CDHS Director.

- **The coordination with similar programs of the Federal Government, other states, and voluntary agencies:** The IHP routinely collaborates with the Federal Indian Health Service (IHS) on Indian health issues. The IHP is currently collaborating with IHS to assist tribal clinics and communities in emergency and bioterrorism preparedness for AI/AN health clinics.
- **Other IHP Activities:** H&S Code Section 124585 (d) also specifies that the program will distribute funds in accordance with a formula and assist programs to maximize third-party payment systems. Additionally, H & S Code Section 124580 requires the CDHS to provide sufficient funding to improve AI/AN access to other service programs within the CDHS including Maternal, Child and Adolescent Health (MCAH); Women, Infants, and Children (WIC) Supplemental Nutrition Program; programs for the aging; etc.

Clinic Funding via the Allocation Formula

IHP primary care funds are distributed in compliance with Health and Safety Code Section 124585 (d) and Title 17, Chapter 3.1, Section 1532, according to a need and performance driven formula that is comprised of five weighted factors.

Factor 1:

Systems Evaluation (SE) (46%): This factor is based on the scored biennial, on-site evaluation of the clinic's Medical, Dental, Community Health Services and Board / Administrative / Fiscal systems. Individual clinic scores are used to determine funding amounts for this component. The SE is conducted using rigorous protocols allowing for clinic preparation time and standardized evaluation processes. This factor of the IHP clinic allocation formula addresses the demonstrated ability of a clinic to carry out proposed services and that the clinic has adequate staff to provide the services

Factor 2:

Foundational Criteria (22%): A clinic eligible for IHP funding must provide at least two of the following three components: Medical, Dental and Community Health Services (CHS). Funds are distributed proportionately according to the service components that a clinic provides. This factor of the IHP clinic allocation formula addresses the ability of the program to comply with the statewide plan for Indian health services and existing priorities for services

Factor 3:

Grant Objectives (15%): This factor measures how well grantees have met the numerical service objectives in their grants. Data to measure achievement of grant objectives are obtained from the number of **visits** reported on the Progress Reports submitted by the clinic. This factor of the IHP clinic allocation formula addresses the number of individuals to be served and the demonstrated ability of the clinic to carry out the proposed services.

Factor 4:

Population Service Index (15%): Funding for this factor is based on the number of **individual** AI/AN patients actually served during the calendar year. Data to measure this factor are also obtained from the progress reports submitted by the clinic. A per capita rate based on the unduplicated patients served by each grantee determines the funds

awarded for this factor. This factor of the IHP clinic allocation formula also addresses the number of individuals to be served.

Factor 5:

Target Population (2%): This final factor recognizes the size of the AI/AN population in a clinic's service area. The population figures used are from estimates of the service area population prepared by the IHS using the U.S. Census Bureau. A per capita figure determines the funds awarded for this factor. This factor of the IHP clinic allocation formula also addresses the number of individuals to be served.

Contact Information

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